Crisis Intervention, 1970, Volume 2, Issue 2

INFORMATION FOR CONTRIBUTORS

CRISIS INTERVENTION is intended to facilitate communication on
(1) programs of suicide prevention centers
(2) clinical aspects of crisis intervention and suicide prevention; and
(3) current issues and research in suicidology and crisis intervention.

CRISIS INTERVENTION is published six times per year. It is sent free of charge to Suicide Prevention Centers.

Manuscripts should be double-spaced and conform to the publication manual of the American Psychological Association. Send manuscripts to: Dr. David Lester or Dr. Gene Brockopp, Suicide Prevention and Crisis Service, Suite 405, 560 Main Street, Buffalo, New York 14202.

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GUEST EDITORIALS

A Look Ahead

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Maximum efficiency in providing crisis services requires close collaboration between health professionals in crisis centers located outside of medical facilities. Such collaboration may be required before, during and after the episode for which services are needed, and necessitates communication with a variety of disciplines related to medicine.

To date there has been limited progress in developing such integration of services, apparently due to reluctance on the part of medical persons, especially physicians, to accept volunteers in the role of collaborators. To the extent that this reluctance restricts the range or adequacy of assistance provided, a disservice is done, and overall therapeutic efforts are handicapped. Since delivery of health care is moving steadily in the direction of a broader range of services to an ever greater segment of the population, this handicap threatens to become greater as manpower shortages increase.

Collaboration of telephone crisis services with medical agencies would be made easier by perceiving the role of the person taking crisis calls not as a “volunteer” but as a “mental health counselor”. Such a role transition would obviously require more than simply changing the occupational label. To have meaning it would be necessary to institute a program of training that provides thorough orientation in all major aspects of mental health. This program would require the equivalent of 9-12 months of full-time training, and would cover a broad range of material from the physiology of the nervous system to the legal and administrative aspects of community mental health services. It would also imply that appropriate pay be provided for services rendered.

It does not require a special capacity for progressive thinking or a forward looking attitude to appreciate the need for this transition. At least two observations have impressed workers in the field so sharply that the forces dictating it would be difficult to deny.

Firstly, the skills of experienced telephone crisis workers constitute a unique and invaluable social resource. This can best be appreciated by professionals who are faced with the problem of managing a suicidal person who requires techniques and time that far exceeds what can ordinarily be offered. Experience has repeatedly borne out the observation that, even with an academic and professional background, special training and intuitive skills are basic requirements for efficient crisis telephone work. Most health professionals in the community, even if they were available for this purpose, would be insufficiently prepared to deal with it effectively.

Secondly, and even more compelling, is the fact that public utilization of crisis centers indicates a need for services that go far beyond crisis situations. Most calls involve a wide

variety of non-suicidal problems for which no appropriate agency now exists – fears, loneliness, a need to talk something out, confession, advice about matters requiring anonymity and a million more. This is especially the case when the distress produced by these problems is most intense at night, when even a 24 hour "emergency" medical/psychiatric facility would, as a rule, give a telephone caller short shrift. Though suicide prevention centers have encountered some criticism because their efforts have gone largely into responding to non-crisis calls, it must be acknowledged that it is only by this means that it can function in a primarily preventive way, i.e., helping persons find means of coping before a crisis arises rather than waiting to intervene in an emergency.

Explosive expansion of health care with attendant manpower shortages, a growing cadre of persons with special skills required to provide a vital preventive mental health service that is nowhere else provided for, and the amply demonstrated willingness (not to say insistence) of persons in need to see telephone facilities as a medium for help – all point the way for a new kind of health "professional". I suggest that "Mental Health Counselor" would best describe the role of this person. It would also further the goal of integrating him into the "health team," which is now the domain of medical and paramedical disciplines.

Responding effectively to these current trends poses a formidable challenge to persons concerned with the development of suicide prevention and crisis oriented services. It remains to be seen whether it is possible for the leaders in this field to take the necessary initiative.

The American Association of Suicidology

David Lester, Erie County SPSC

Today, there are many societies, academies, and associations which seek to help scientists or practitioners with particular interests to meet together and to communicate through journals and conventions thereby to further knowledge in these particular fields.

The practices of some of these associations leave mach to be desired. For example, the American Association of Suicidology operates under the following undemocratic procedures:

(1) The first four presidents of the association and all officials have been selected by a committee (whose selection and exact composition is not known to me, a member of the association) and presented to the members for a vote without alternative candidates. Thus, in essence, the officials are appointed to their positions. This of course can open an association to charges of nepotism and favoritism.

(2) The members of the association are not informed in advance of the items to be discussed at the annual business meeting. This makes discussion and consideration of the issues difficult. In fact, most of the issues are presented to the membership as *faits accomplis*, being decided in the period between the annual meetings. Thus, the technically elected (but essentially appointed) officials are able to decide upon issues without interference from or responsibility to the membership.

It appears that there is a need for a set of standards by which associations should operate to encourage them to move toward a greater concern with both the advancement of knowledge and democratic procedures and to minimize the charge that is sometimes made that some associations exist primarily for the self-aggrandizement of a small group of individuals.

The American Association of Suicidology could be important in assisting and aiding those interested in the study and prevention of suicide. I would urge the members of the association to encourage the association to move toward a more democratic and altruistic orientation.

PROGRAMS

The Suicide Prevention-Crisis Service, Corpus Christi, Texas

Marjorie J. Stuth, Christi, Texas

In late 1966 a group of concerned citizens of Corpus Christi, Texas met to discuss the possibility of a 24-hour mental health, crisis intervention service. No agency was providing this service, and the need for it was generally recognized in the community. Of particular interest was prevention of suicides by intervening in crisis situations which might otherwise lead to suicide. A committee was formed, and a local church paid the expenses of a group of personnel from another such agency in the state to come and share their experiences in opening a center. Local mental health agencies were consulted, as well as individual psychiatrists, psychologists and psychiatric social workers. With the assistance of these professionals, an organization was formed, which recruited, screened and trained its first group of volunteers. Enough money was raised to pay the phone bill and rent, and advertisements were placed in local newspapers and over radio and television. Suicide Prevention, Inc., began its operation on February 10, 1967.

Until the end of the third year there was no payroll. From the professional who administered psychological tests, screened and trained telephone workers and provided consultation, to the clerical workers, everyone in SPI was a volunteer. Funding was extremely limited and was entirely obtained from private sources until 1969, when SPI became a United Fund agency was able to hire a part time secretary. In late 1969 the name of the agency was changed to Suicide Prevention-Crisis Service to more clearly identify the actual work of the agency. At present, SP-CS is receiving only limited funding from United Fund and the only paid staff remains a part time secretary.

SP-CS is the only 24 hour Mental Health service agency in South Texas. Cooperation is close with all other mental health agencies as well as with many other types of agencies. Our main role is to serve as the “bridge” between the troubled caller and the agency or resource which can help him. Staff volunteers are trained to make a realistic appraisal of the needs of the individual who calls and the extent to which he is able to respond to community resources. When resources are available, the staff volunteer completes an effective transfer of the caller to the most suitable resource. In some instances, the telephone contact with the staff volunteer is sufficient to alleviate the caller’s anxiety and no transfer is necessary.

In addition to the telephone service, SP-CS has a team of specialized volunteers who are assigned to make face-to-face calls to the suicidal person who has no other resources available to him or who is unable to utilize such resources. In critical cases, the co-operation of the city Police Department is also obtained.

Quite recently services were expanded to make an effort to reach the individuals in the community who attempt suicide but do not call us. Originally personal contacts were made and proved quite successful during the short period of time we were able to do this. But due to lack to manpower, personal contacts were discontinued and presently our efforts to reach the attempter are made by telephone, with face-to-face contacts provided if warranted. Although this phase of our program has not been in effect long enough for a realistic evaluation, response has been good.

Since the beginning, the number of calls to SP-CS has increased each year. In 1969 we received 923 calls, an increase over 1968 when 674 calls were received. These calls involved 563 cases, 437 of whom were new callers who had not contacted the agency before. Although the majority of our calls are from the Corpus Christi metropolitan area, we do receive a significant number of long distance calls, some from as far away as the State of Washington. Of the 563 callers in 1969, 30 percent were considered suicidal. The remainder were classified as persons with psychological problems, psychotics, and persons seeking information.[1] Sixty-four percent of the callers were women. Fifty percent of the callers were persons under 30 years of age. Follow up is attempted in all calls in an effort to determine our effectiveness. For various reasons, such as anonymity of callers, referral to family doctor whose name is not revealed, no response from follow up letter, etc., we have no way of knowing exactly what our real effectiveness rate is. However, in 1969 a minimum of 27.4 percent of our callers sought the help we suggested within two months of the call. The effectiveness rate increases significantly when a face-to-face team is involved. The agency receives its share of chronic callers who call as often as once a day or as irregularly as every other month or so. These callers refuse to accept referrals, block the telephone volunteer in every way, and because of their obvious need are generally frustrating to the entire staff. When potential chronic callers are spotted, the case is referred to one or more members of the Professional Advisory committee for consultation. Upon the advice of the professional(s) who review the case, a specific method of handling the caller is agreed upon and the entire staff is called upon to conform to the recommendation. Through this effort we have been able to help some callers who would probably not respond to the many individual approaches.

A vital part of SP-CS is the Educational program. Volunteers initially receive 24 hours of classroom training in the psychological needs of persons in crisis situations, human behavior, interviewing techniques, community resources, and the structure and policies of the agency. These sessions are taught by local mental health professionals and by experienced volunteers.

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[1] This total number does not include very short informational calls or prank calls. There were 50 such informational calls and 120 prank calls.

Training sessions are supplemented by reading assignments of keynote papers by leading authorities in the area of suicide prevention and crisis intervention. A battery of psychological tests is administered to enable potential volunteers to identify their own areas of weakness and thus improve their own functioning. Screening consists of two parts. One is the general impression the teachers get from the potential volunteers during the training sessions. This works best of course when the group is small and, when we have an unusually large group of trainees, they are broken into smaller groups for discussion. Our second method of screening is accomplished by role-playing with the potential volunteer taking a simulated "call" from an experienced volunteer playing the "caller." Actual case histories are used in role-playing. This has proven to be one of the most effective tools in screening because it provides those responsible for choosing new volunteers with indications of the potential volunteer's ability to handle his own anxiety in stress situations, his ability to relate to troubled people, and often times personal prejudices which he is unable to disregard in dealing with callers. Discussion following role-playing reveals the potential volunteer's ability to receive and act upon constructive criticism and his willingness to follow agency policies and accept supervision. The applicant is aware from the beginning that our standards are high and, if he is not accepted for phone duty, there are other, very important roles in SP-CS open to him.

These initial training sessions are held five times a year, and the first half is open to the public. The last half is designed exclusively for the use of those persons who have expressed an interest in joining SP-CS, and we invariably get people to join us who had come to the training with only their own education in mind. Although most of our training sessions are held at night, we have at least one during the year in the daytime for housewives who want to participate but must tend to family responsibilities in the evenings.

Following the initial training and screening, volunteers who are chosen are assigned to on-the-job training with an experienced volunteer. After successfully handling his first few calls and with the recommendation of his supervisor, he is assigned to his own shift. Ideally, because we have two telephone lines, there should be two people on each shift, but as yet we don't have that kind of manpower.

Supervisors are chosen from the ranks of experienced volunteers and undergo further role-playing and training in supervision, as well as on-the-job training under an experienced supervisor. The supervisory system provides for a supervisor for each shift, available to the telephone volunteer for consultation. Volunteers must report all calls to their supervisor, and the supervisor is responsible for the on-going training of volunteers on his shift. Small shift meetings are held once a month with the supervisor to discuss cases, procedures, and the handling of calls. By means of these small group meetings (7 volunteers and one supervisor), as well as regular contact with volunteers in regard to incoming calls, supervisors are able to be aware of the volunteer's functioning and work with individual volunteers on any problems they may be having. If, for example, a volunteer is having personal problems which may affect his work on the telephone, or he is unable to cope with a certain repeat caller, this is spotted early so steps can be taken to remedy the situation. If necessary, volunteers can be requested to take a leave of absence. This rarely happens, as supervision is supportive and volunteers are from the beginning sensitized to their own pathology so that they are the first to recognize the need for a leave of

absence and act accordingly. Supervisors meet together once a month with the Staff Director for discussion of cases, volunteer effectiveness, and agency needs. Both telephone volunteers and supervisors are required to attend monthly general training sessions which usually consist of lectures, films, or panel discussions in areas of knowledge essential to the effective functioning of the telephone volunteer.

Face-to-face team members are chosen from experienced volunteers and are screened through role-playing. They then receive further training in the area of first aid and emergency health precautions and the dynamics of a face-to-face call, and become secondary members of a face-to-face team before being assigned to a permanent position. Team members meet once a month with a professional consultant for discussion of cases and further training.

In addition to the extensive training program within the organization, SP-CS has since the beginning undertaken community-wide educational programs. Each year, often in co-operation with other mental health agencies, seminars are held in the general area of crisis intervention. These seminars, while often open to the public, have been aimed at the "gatekeeper": ministers, doctors, nurses, mental health volunteers, etc. We have in the past brought in nationally recognized authorities to present these seminars. One result of these co-operative efforts is that we have developed close working relationships with other agencies, and referrals are increasing from ministers, doctors, and many others including policemen who carry our cards with them and are pretty much "on the front line" with troubled people.

A third aspect or our educational endeavor is our speaker's bureau, consisting of knowledgeable volunteers who, upon request, address civic organizations, social clubs, service clubs, school classes and organizations, church groups, and any other groups who may request it. These brief programs are focused on educating the public to the needs of individuals in crisis with whom they may come in contact, our availability and function, and the resources and needs in the community in the area of mental health. Often, as a direct result of these programs, we receive both callers who were unaware of our service and future volunteers.

Suicide Prevention-Crisis Service has developed from a small, relatively unknown organization to a large, well-known and highly respected agency which fulfills a vital need in the community. We are aware that there are many more needs, and are striving to fulfill some of these. Uppermost is funding for a full time Director and professional consultant services, as well as increased secretarial staff. In the early planning stages is some co-operation with the Mental Health-Mental Retardation Community Center program with the future possibility of the development of a 24 hour Crisis Clinic with adequate staff. Our research from our statistics shows that there is an urgent need for special services for youth, and we are now considering the development of a "Hotline" directed toward teenagers. This would require special screening, staffing, and training of youthful volunteers with whom teenagers can more easily relate, as well as funding for a Director and consultation services. Experience has shown that our effectiveness is much greater when face-to-face contacts are used, and we would like to expand this service. We can see the urgent need for a full time effort to reach the suicide attempter, preferably utilizing paid professionals to make personal contacts and provide direct services. Our ultimate

goal is working with all agencies to help provide a completely comprehensive mental health program in the community, with help available to all who are in need.

Using Clergymen as Night People Counselors[2]

John Russell, M.S.W., Erie County SPCS

The Program

Night People is a community mental health reach-out program in downtown Buffalo, New York, under the auspices of the Suicide Prevention and Crisis Service of Erie County, New York. The Night Counselors who man the program are clergymen of several denominations who have been trained by our agency. The counselors take 6-hour shifts from about 10:00 P.M. to 4:00 A.M., moving around in areas of high night activity, being visibly available for contact and counseling in such places as bars, coffee shops, hotels, transportation centers, and on street corners. The counselors encounter a variety of people, drawn to them by the sight of the clerical collars, whom they engage in conversation, often moving into discussion of problem areas in their lives or of crises they are currently undergoing. The Night Counselors attempt to listen in a sensitive and accepting manner, and to give a therapeutic dimension to the encounters, by helping the person reflect on their problems, by discussing alternatives to situations, by strengthening self concepts, by inserting resource suggestions, and by making referrals for specific problems that may come up.

History

Using clergymen as counselors in the milieu of night life or the entertainment world is not a new concept. Many major cities, including New York, Chicago, and San Francisco have similar programs, usually called Night Pastor programs. Most of the programs are solo operations based on the charisma, motivation, and skill of a single pastor, and backed up by financing and sanctions from Church organizations.[3] A few such night counseling operations, such as the one in Grand Rapids, Michigan, have ventured to use teams of clergymen.[4] To our knowledge, the SPCS, Night People program of Erie County is the first such attempt to use teams of clergymen based in a secular, non-ecclesiastic organization, supported by public mental health funds. In so doing, we find we are involved in a broad-based program, not dependent on just one individual's charisma and personality, and not couched in typical religious terms of redemption and salvation. The program has strong back-up from the professional and lay therapists and counselors of our other center programs. We began to develop our program in October, 1969, with the appointment of a part-time clergyman who has social work training. Three counselors were trained in January and February, and our program hit the streets in mid-

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[2] A paper presented at the American Association of Suicidology, San Francisco, 1970.
[3] For a review of these programs, see Matthews, Stanley, G. The Night Pastors. New York: Hawthorn Book, Inc., 1967.
[4] The Grand Rapids Youth Ministry, Grand Rapids, Michigan.

February. We are currently assessing our first month of operation, reviewing our training program with plans to conduct a second program in mid-April.

Night People

One of the first questions we had to face both during the program development phase and during our training period was the definition of our target client group. We approached this by defining several target areas where there is a high concentration of night-life, and then exploring and analyzing those areas to try and identify who our clients would be. From this activity, we generally defined Night People as that segment of the populace that seems to function best at night, either by choice or necessity, and whether at work, at play, or while enduring crisis. More specifically, we found three groups of people:

1) People who earn their living at night in such night trades as bar tender, waitress or bar maid in night establishments, and entertainers, ranging from Go-Go dancers to prostitutes. Also included are such groups as clerks employed in all night stores and services, cab drivers, and policemen.
2) Persons who, because of restlessness, troubles or travel, find themselves drawn to areas of night activity.
3) Certain chronic social sub-groups such as alcoholics, homosexuals, and the lonely elderly.

Counseling

Our approach to the potential client, in his own milieu, is non-aggressive, and dependent on movement first by the client, and the subsequent build-up of trust and understanding. Our counselors are secure and competent enough to handle almost any kind of approach to them in an accepting way that is also reasonable and appropriate. Most approaches made to our counselors are those made out of curiosity because of the collar, though not a few people have begun to interact with us simply on personal grounds, not noticing the collar at first, and sometimes being quite surprised when they learn that the counselor is a clergyman or priest. Occasionally, hostile approaches are made, either through ridicule, disbelief in what the client sees, or on two occasions, by being attacked physically. But we have found that if the hostile approaches are handled without panic, even these beginnings can produce fruitful relationship.

After being on the street a month, we find that we are increasingly recognized and accepted. We are greeted with a wave or nod, and find that people whom we have encountered before, upon seeing us again from a distance, will begin to explain to their colleagues who we are and how they got to know us. Others will plunge into old topics of discussion. During our last two weeks, persons we have met have begun to introduce us to other persons, suggesting that we talk to them about their problems.

It is important to our approach that we do not see our clients in any stereotype, and that we do not see our primary task as that of intending to “rescue” those we meet, or rehabilitate or change them. We are, rather, more concerned to establish warm, sensitive, and accepting human contact on a highly individual basis, to begin to communicate, without demands, or without

presuming that we know the person's situation or "what is good for them." Though many people we meet may be coping with both chronic problems and crises in maladaptive ways, we have learned to recognize that they are at least coping, and we do not presume to judge their coping mechanism, letting them asses their own reality situation, and helping them to do this. We seldom ask questions, and are slow to make suggestions.

As contacts are made, crises encountered, and trust built, problem solving often takes place. We may make a job referral, find a place for someone to stay, plan a social service resource follow-up, buy a meal, get medical help, or go to a hospital. It appears that in some instances, some clients may desire to enter a regular therapy relationship, though this is not primarily what we are offering. Should this occur, we use the resources of the SPCS center to back us up. From this point in our development, it appears that our counseling is in three chief areas of activity, often developing sequentially in the order listed below.

1) The counselor, being sensitive to what he communicates by his presence and his demeanor, demonstrates interest and availability just by his presence, in a non-aggressive and non-prying manner. He is simply visibly available for conversation, and also to provide a warm and sympathetic human contact, lend a listening ear, and respond to curiosity in an open way to those who approach him. We feel that this kind of contact reaffirms life and gives a sense of identity to many who talk to us.
2) Through the able process, relationships are built which we believe have a salutary impact on the client's mental health and self-image. As rapport develops, certain persons in crisis identify themselves, whom the counselor can help by therapeutic reflection and by exploring reality and possible solutions. The counselor may offer to plug the person into an appropriate community resource to help with his crisis. We are careful, however, in our service as a gatekeeper to community resources, that we are not seen as primarily interested in huckstering the resources to persons who, though they may need them, are not ready or willing to receive them. To do otherwise, we feel, would be depersonalizing.
3) Through the rapport and reputation developed in the above counseling activities, increasing amounts of trust and acceptance on both a personal and community level are being established, and clients are referring other clients to us, and it seems that we will be led to developing therapy for certain clients. Because of our association with the Suicide center, we find that a number of the persons we have met claim to have been involved in suicide attempts.[5] Such persons may in time become patients of the SPCS clinic, with a stable helping relationship being established.

Training Program

The training design for night people is built on the belief that clergymen already posses substantial skills in building human relationships and in counseling derived from seminary training and from their experience in pastoral counseling. As "Gatekeepers," we presumed that

[5] In the course of our first month, four persons have so identified themselves, and we have had occasion to follow up one such client, and in the process verified the suicide attempt.

they have a background in the identification of psychosocial needs and pathologies, and a knowledge of referral procedures. To this basis we attempt to add training in sensitivity to what we communicate as clergymen and as people in our role as Night Counselor. We have been particularly anxious to weed out through a process of self-counseling, those clergymen who might be too judgmental, too moralistic, or too dogmatic to function with Night People, in line with our belief that such attitudes would hamper the delivery of mental health services to Night People. Additionally, we wanted to familiarize the clergy with the environment, and wanted to be sure they knew enough about themselves to be able to deal with people who would respond differently to them than would their own normal middle-class constituencies. Finally, we wanted to add certain didactic information about community resources, crisis intervention, and suicide to their basic knowledge, and build up a basis for further training and group supervision.

Our training program was divided into four blocks, as follows:

1) Three seven-hour sessions on consecutive days in encounter groups focusing on certain issues that we saw in the Night People program, namely,
    (a) The potential validity of the program as a reach-out vehicle for mental health counseling;
    (b) The implications and effects of clergymen staffing such a program;
    (c) The ultimate goals for therapy and counseling in the program.

In this process, we considered other programs in the nation, digested our own program design, considered the cultural differences between the world of Night People and our own worlds, and considered the stereotypes of clergymen that we have of ourselves and each other, and that others have of us. Finally, through the use of psychodrama techniques, we projected ourselves into the role of Night Counselor to begin to find ourselves in this role. Throughout these three sessions, our emphasis was on our ability to communicate, to listen, and to perceive ourselves.

2) Following the encounter groups, we embarked on a 3-day, two night, anonymous, individual "live-in" or "plunge" into the Night People area, using limited financial resources.[6] The goal of the plunge was to immerse ourselves in the Night People culture, and to gain familiarity with the geographical area in which we would be working, and with the people who would be our potential clients.
3) Our third block of training, following the plunge, was a marathon sensitivity group wherein we proposed to work out and understand our experience from the plunge, and develop a method of operation as Night Counselors.

Our fourth block of training, consisting of didactic material and evaluation in the group setting of our counseling experiences, began as we actually moved into the streets as Night People counselors, and simply continues on into on-going supervision.

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[6] The "plunge" was originally developed by the Church Urban Training Center in Chicago, Ill., with whom we consulted while developing our training program.

Results of the Training Program

Recruiting for the Night People program was limited to clergymen who were thought to be suitable candidates because of apparently non-rigid attitudes and community involvement. Response was initially enthusiastic, and eleven clergymen, including the director of the program and the trainer, came to an initial meeting, all much attracted by the novelty of the program.[7] However, before training began, four clergymen dropped out, giving as reasons lack of time for the program. In addition to the remaining seven clergymen, four laymen were added to the group, three of them women, for purposes of group balance, and to explore the possibility of using laymen and women as counselors. At the end of the first three blocks of training, the four lay persons and one clergyman dropped out, giving as their reason their experience of cultural shock during the plunge, feeling that they could not fill the role as we envisioned it, and could not communicate in any meaningful way with Night People. Two other clergymen counseled themselves out during the initial encounter groups, discovering that they did not know enough about themselves in groups to be comfortable with the training. Our net result was four clergymen who were willing and motivated to be counselors in the Night People program.

The high attrition rate during training is a fact not easily understood. It could that our training accomplished precisely what it set out to do, namely, to weed out those clergymen who were not good candidates for the task. Or it may indicate that clergymen, except for a special few, are not suitable for the task. However, time pressures on all the men are a real factor. Additionally, we are operating under the handicap of not being able to pay any more than a meager expense allowance for the counselors. The counselors are regularly experiencing expenses over the allowance, and all have chronic time and income pressures that might be greatly alleviated if we were able to find funds to pay them as professionals working on a part-time basis.

Other Aspects

Concurrently, with the recruitment and training for the program and operation of the program, we find it necessary to do a lot of community organization work. The cooperation and involvement of the major downtown churches is being sought. We are attempting to identity and recruit indigenous Night People to serve on our advisory committee and to help us develop and man a store-front center. We are seeking to win acceptance of our program from groups with proprietary interests who are naturally suspicious of us, such as bar owners and policemen. We are developing a publicity program that is two pronged: first, to appeal directly to the Night People, and second, to win the support and understanding of the greater Buffalo community. This has involved posters, cards, letters, calls, meeting, speaking engagements, and television.

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[7] Our trainer was a clergyman from outside the agency, who is a certified trainer from the National Training Laboratories, Bethel, ME.

Ultimately, we hope these community contacts will prove so fruitful that we will be able to spin off to the sponsorship of an existing community agency or coalition, the Night People program, complete with personnel and method of operation.

Summary

This has been a report on the first six months of a mental health reach-out program using clergymen as counselors in bars and night spots. Following development and training, the first month of the program's operation indicates that it is feasible to use clergymen as counselors, and that they do stimulate meaningful contact with a large group of persons we call Night People, who do not normally avail themselves of mental health and crisis services. During the first month, 10 percent of our more meaningful contacts have been with people who claim to have attempted suicide. Rapport with the clientele of our target area is increasing noticeably. We see a continued development of the program along this line.

Questionable, however, is the high rate of attrition of clergymen who have been recruited for the Night People training program. Their reasons for dropping the program include not enough time, inability to deal with the cultural shock experienced in the world of Night People by clergymen. This result may indicate that our training program is doing a good job of screening, or that we need to find a more realistic way of recruiting and training clergymen to be Night People counselors. Undoubtedly there is a problem of both time and expense for all the men who have been involved. Despite the initial success of our counselors, we may have to face the fact that there may not be enough clergymen available with the requisite combination of aptitude, time, and motivation to do the job.

The Differentiation of a Telephone Service

Gene W. Brockopp, Erie County SPCS.

In most 24-hour emergency telephone services, the major way of assisting individuals in difficulty is through a telephone, usually publicized under the general rubric of a suicide prevention center, a crisis service, or a combination of the two.

Through analyzing the telephone calls of the first six months of telephone service at the Buffalo center, we noted (as many other Centers have noted) that most individuals calling the Center are not actually suicidal or even contemplating suicide. Our figures indicated that approximately 80% of the individuals call because of other problems and concerns. Often they will call the center and make the disclaimer "I am not going to kill myself but I have this problem or concern and I want to talk to somebody." or "I can't get help anywhere else, maybe you can help me." In looking at the problems people were having through the calls we were receiving, we felt that the designation of the 24-hour telephone emergency service under the term "Suicide and Crisis Service," could be a stumbling block for individuals, and could possibly prevent people from calling the Center with other problems they may have, (which may have a

suicidal aspect although they were not defined as such by the people calling) because of the ethical and religious connotations which the community attached to suicidal behavior.

We decided to explore other ways to label our telephone service to facilitate the movement of individuals with problems to the Center and then through the Center to a helping network of people. Our initial movement was to develop a broader designation that would allow individuals with a wider range of problems to feel that they could call the center. Out of the many choices that were available, we selected the term "PROBLEMS OF LIVING" since it defined problems in a non-psychiatric or sick manner, gave them sense of normality, and did not circumscribe problems according to age, sex, or type of difficulty.

The second differentiation was in term of specific problem areas or age groups. Again analyzing the phone calls received at the Center, we felt there was a need to contact or to develop a telephone service which would focus on the teens and twenties population. It was felt that the teen's population would be more likely to call a telephone service if it was designated as being specifically focused on them, and on the problems that they had. Also, we felt that many of the telephone therapists on the Suicide Prevention Line, even though they would be facilitative in assisting people with more severe problems, would have a more difficult time handling the problems of the teenagers who call on the suicide line since the adults tend to define these problems in a non-serious way.

One of the problems with which we became concerned after developing the three telephone numbers, was that we were moving rapidly toward a proliferation of telephone numbers, each one designed to reach a specific population. We were on the way to flooding the population with a mass of emergency telephone numbers forcing them to make discriminations among which numbers to call for a service. When we were recently asked by the Mental Health Department to consider developing a number designed to reach individuals with drug problems, we became acutely aware of this problem, for in less than 18 months we would have given the community four different telephone numbers to be called by individuals with various types of difficulties.

In attempting to work out a solution for this problem, we came back to the Problems of Living number, which because of its ambiguity and breath, could be used to encompass the drug problem with which we were concerned or any other problem that might develop in the community in the future and require a specific number for a period of time in order to facilitate the movement of individuals to the center.

With this in mind, we have taken the following direction in the differentiation of our phone numbers:

The PROBLEMS OF LIVING line is designated by the number 854-5655 and is a series of numbers from 5655 through 5660. By splitting this series of numbers into two units of three numbers each; e.g. 5655, 5656, 5657 and 5658, 5659 and 5660, we could advertise the second series; 854-5658 as the drug line and answer it as the drug line. In the future, by merely changing

the last digit from 5658 to 5655, we could effectively move the number back into the PROBLEMS OF LIVING unit, and again leave the last series of three numbers available for a new kind of problem whenever one has been defined in the community. This would allow publicity to be developed for a specific number designated by a problem area, and it would keep the proliferation of telephone numbers to a minimum, since as the problem area became less "hot" in the community, it could be subsumed under the PROBLEMS OF LIVING line, and could be advertised as such in the community.

We feel for any telephone therapy service to be effective, the service must be defined in such a way as to facilitate the movement of individuals to the telephone service. Therefore the way the phone is listed must be defined in a way which is seen as facilitative by the individuals who are in difficulty or in a way which encompasses their problem, and allows them to feel that they can receive the assistance that they need from this service. To accomplish this, it appears to us that the differentiation of the telephone line from a suicide prevention or crisis service into a broader area, and into more specific problem areas (as they become defined) is essential if we are to be open to the needs of the community.

The concept of telephone therapy is still a new one in the professional community. How it will develop and differentiate and what will be the best ways in which it can be defined, is still to be determined. It is apparent from our work in Buffalo that each community must find its own way to define its telephone emergency service, that this service must be defined in terms of the problems the community has, so that the service can facilitate the movement of an individual in difficulty to the appropriate community resources.

A Comparison of the Callers to the Three Telephone Services of the Erie County SPCS

David Lester, Erie County SPCS.

The Erie County SPCS has three telephone services in operation (Brockopp, 1969): (a) The Suicide-Prevention and Crisis Service, (SPCS) (b) The Problems of Living Services, (PLS) and (c) The Teenage Problem Service (TPS). Each of these three services has a different telephone number.

The Suicide-Prevention and Crisis Service has been in operation since November 1, 1968 and has been widely advertised through various media. The Problems of Living Service has been in operation since August 25, 1969 and at present is advertised only in the telephone directory and through a small three-line advertisement in the two Buffalo newspapers as follow:

> DEPRESSED? Disturbed? No where to turn?
> Call Problems of Living Service. 24 hours
> 854-5656.

The Teenage Problem Service began operation on November 5, 1969 and has been advertised through a variety of media.

The present paper examines the characteristics of callers to the three services. The sample consists of the 74 new patients who called the SPCS and the 124 new patients who called the TPS during the week of November 8, 1969 to November 14, 1969, and the 93 new patients who called the PLS in the three week period from 11/1/69 to 11/21/69.

Demographic Characteristics of the Caller

The callers on the three lines did not differ in sex. On all lines, about 70% of the callers are female (see Table 1). The callers on the three lines did differ in age and marital status, however.

The data on age is not completely reliable, for counselors are asked to estimate ages where possible if the caller does not give his or her age. The caller to SPCS is usually between 10 and 45 years of age with the modal caller being aged 10 to 19. The caller to the PLS is in the same broad age range (10 to 45) but the age of the modal caller is 35 to 44. As expected, on the TPS the callers are primarily aged 10 to 19.

The majority of callers of the SPCS are either single or married, (rather than divorced, separated, or widowed). The callers to the PLS are more likely to be married, divorced or separated and less likely to be single than the callers to the SPCS. As expected, the majority of callers to the TPS are single.

TABLE 1: The demographic characteristics of the callers to the SPCS, PLS, and TPS.

		SPCS	PLS	TPS
Proportion who are females		72%	66%	69%
Age:	0-9	0%	0%	2%
	10-19	27%	13%	81%
	20-24	9%	6%	2%
	25-34	15%	22%	2%
	35-44	12%	24%	0%
	45-54	5%	9%	1%
	55-64	4%	3%	0%
	65-74	0%	1%	0%
	75 +	0%	0%	0%
	unknown	27%	23%	11%
Marital Status:				
	single	36%	19%	89%
	married	31%	37%	3%
	sep/div	9%	17%	2%
	widowed	1%	1%	1%
	unknown	22%	25%	6%

Characteristics Of The Call

The proportion of callers who remain anonymous runs at about 60% for the SPCS. The proportion is a little higher for the PLS and much higher for the TPS (see Table 2). The callers to the PLS and the TPS are less likely to be calling on behalf of another person and more likely to be calling for themselves than the callers to the SPCS.

The distribution of calls over the days of the week differs considerably for callers to the three services. Whether these differences are stable is not ascertainable from the present data.

The busiest times for calls for the SPCS is from 9:00 am to midnight with the hours of 6:00 pm to midnight being the busiest. Calls to the PLS follow a similar temporal pattern. Calls to the TPS, however cluster in the hours 3:00 pm to midnight.

The mean length of calls to the SPCS and the PLS is about 23 minutes whereas calls to the TPS average about 13 minutes.

TABLE 2: Characteristics of the calls to the SPCS, PLS and TPS.

	SPCS	PLS	TPS
Proportion anonymous	57%	67%	83%
calling for another	23%	8%	10%
day of week:			
Monday	16%	12%	5%
Tuesday	16%	13%	28%
Wednesday	12%	8%	12%
Thursday	12%	19%	10%
Friday	15%	23%	19%
Saturday	11%	12%	8%
Sunday	18%	14%	18%
proportion traced	1%	0%	0%
hour of calls:			
mid - 3 am	9%	8%	2%
3 am - 6 am	1%	4%	1%

6 am - 9 am	4%	2%	1%
9 am - noon	12%	15%	2%
noon - 3 pm	11%	18%	8%
3 pm - 6 pm	12%	6%	20%
6 pm - 9 pm	23%	24%	36%
9 pm - mid.	23%	20%	27%
unknown	4%	2%	2%
mean length of calls in minutes	23.7	23.2	12.6

The Problems Presented To The Three Services

About 15% of the callers to the SPCS have a history of suicidal attempts and about the same proportion are categorized as presenting a problem of suicide to the counselor (see Table 3). On the PLS and the TPS the proportion of suicidal callers is much lower. Only about 1% of the callers on these latter two services are categorized as presenting a problem of suicide to the counselor. The problems presented to these latter two services also tend to be rated as less severe than those presented on the SPCS.

The problems presented on the PLS tend to be similar to those presented on the SPCS except that there are fewer suicidal problems and more categorized as "other," such as legal, financial, etc. Problems presented on the TPS are more often sexual/pregnant and adolescent turmoil than on the other services.

Calls to the TPS are more often resolved by means of the telephone call than calls to the other two services (perhaps because they are less serious) and the callers are less likely to be referred to the face-to-face therapy programs of the center or to another agency or told to call back. They are more likely to be advised to consult with a friend or relative. The proportion of calls ended by the caller hanging-up is about the same on all three services (about 10%).

TABLE 3: Problems presented to the SPCS, PLS and TPS

	SPCS	PLS	TPS
Suicidal history:			
History of attempts	14%	4%	2%
Current suicidal Behavior:			
threats	15%	3%	2%
attempting	7%	1%	0%
Suicidal risk:			
not rated:	72%	74%	81%

1	9%	16%	16%
2	4%	5%	2%
3	7%	2%	1%
4	4%	1%	0%
5	4%	1%	0%
Severity of problem:			
not rated	72%	59%	65%
1	9%	9%	16%
2	7%	8%	9%
3	7%	15%	9%
4	1%	8%	2%
5	4%	2%	0%
Major presenting problem:			
family	34%	35%	26%
sexual/pregnant	3%	4%	15%
lonely/depressed	18%	17%	6%
suicidal	15%	1%	1%
school/employment	4%	0%	10%
adolescent turmoil	4%	2%	30%
other	22%	41%	12%
Disposition:			
hung-up	9%	12%	10%
resolved over telephone	19%	17%	38%
referred to center for therapy	11%	10%	2%
call back	26%	23%	12%
talk to friend/rel.	3%	2%	19%
other	32%	36%	19%
Seen at center for face-to-face therapy	4%	3%	1%

Discussion

The three telephone counseling services offered to the community clearly tap different populations and different problems. The individuals calling appear to be able to differentiate between the services. For example, calls from suicidal individuals come into the center on the SPCs line regardless of age. They rarely come in on the TPS or PLS.

It appears therefore, that distressed individuals in the community with problems who might not call a suicide prevention service (perhaps because of a stigma attached to calling a service with that name and perhaps because their problems do not seem serious enough to warrant calling a suicide-prevention service) may use another service, such as a problems in living service. This is important for, by providing individuals with a service which they can call with any size of problem and which is suitably labeled so as to have little stigma attached to calling it, we can perhaps aid individuals before the individual becomes seriously distressed. By intervention at an earlier stage, we may be preventing more serious (and possibly suicidal) crisis from developing later.

Reference

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CASES

An Analysis of "Nuisance" Calls Received by a Suicide-Prevention Center

David Lester, Erie County SPCS

The suicide-prevention center in Buffalo maintains a 24-hour telephone service for people who are in need of advice or who are in a crisis situation. Among calls received by the center are some which the center labels as "nuisance" calls.[8] These calls are defined in the following way. During the day a receptionist answers the telephone with the words "Suicide and crisis service. May I help you?" The caller may hang up or may remain listening in silence. He may respond with a brief statement such as "No," I'm going to kill myself," or "Screw you" and then hang up. If the caller responds seriously the receptionist will transfer the call to a counselor. The caller may hang up while the call is being transferred or he may respond to the counselor in the way described above. At night incoming calls are taken directly by the counselor.

These "nuisance" calls differ from "serious" calls in that the caller does not present a problem to the counselor and ask for a solution. "Serious" calls may indeed include pranksters, but they are characterized by an interchange of statements between the caller and the counselor. (In fact, we have no way of knowing whether problems presented to the counselor are valid or fraudulent just from one telephone conversation.) Of course, some of the calls defined here as "nuisance" calls may be from patients or potential patients who lack the courage to begin an interchange with a counselor. This may be true of calls classified as "hang-ups" (no words exchanged) but it is less likely to be true of the obscene calls. The "nuisance" calls are defined as a nuisance by the receiver of the call (in the present instance, the Suicide Prevention Center) and the definition does not take into account the intent of the caller. This parallels the definition of a

[8] 'Nuisance" is a poor word but it is used by the staff of the SPCS for convenience. "Incomplete" is a less evaluative and more appropriate word.

nuisance call used by those investigating such calls received by the general population (Murray, 1967).

The rate of incoming nuisance calls at the center was high and it presented an opportunity to analyze the type of calls into simple categories in a situation that allowed immediate documentation of the call in terms of time of day, date, type of call, word spoken (verbatim), and sex of caller.

Method

The staff at a Suicide-Prevention Center was instructed to keep an accurate record of all nuisance calls coming into the center. Nuisance calls were defined in the introduction above. This definition was based upon the normal practice of the center. The data reported in this paper come from a 42-day period in the Spring of 1969.

General Results

The total number of nuisance calls received was 1,058, an average of 25.3 a day. These calls were classified into simple categories: 803 were hang-ups in which the caller uttered no words, 23 had only sounds of breathing, 56 were wrong numbers, 19 were brief threats of suicide, 12 were obscene, and 145 were classified "other" (a series of words neither obscene nor constituting a threat of suicide such as "hello", "I have a problem", etc.).

There was no significant difference in the number of calls made by males and females,[9] 97 calls were made by males and 107 by females ($X^2 = 0.49$, df = 1).[10]

The calls came significantly more often in the afternoon and evening. From midnight to 6:00 am there were 97 calls, from 6:00 am, to noon 98, from noon to 6:00 pm 354, and from 6:00 pm to midnight 509 ($X^2 = 467.17$, df = 3, $p<0.01$).

Males made significantly more obscene calls and suicidal threats than females whereas females made more calls that were classified as wrong-numbers or "other" than males ($X^2 = 4.29$, df = 1, $p<0.05$).

A chi-square test to determine whether males made more calls at certain times of the day than did females was not significant on the overall contingency table ($X^2 = 5.62$, df = 3) but a comparison of the hours midnight to 6:00 am with the rest of the day indicted that males made more calls between midnight and 6:00 am than females whereas females made more calls between 6:00 am and midnight than males ($X^2 = 4.34$, df = 1, $p<0.05$).

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[9] Occasionally, counselors could not identify the sex of the caller from the voice; also occasionally a counselor omitted to record the sex of the caller.

[10] Siegel (1956) was used as guide for statistical tests.

A chi-square test indicated that hang-ups occurred in greater proportion later in the day than earlier in the day as compared to calls in which the caller uttered one or more words ($X^2 = 8.04$, df = 3, $p<0.05$).

The Effect of Advertising

During the first part of the period covered by this paper, the radio and television stations in the area were carrying advertisements about the center. The mean number of calls per day in the 10 days before these advertisements were stopped was 35.3 and the mean number per day for the first 10 days after the commercials were stopped was 12.5. This drop in the number of nuisance calls was significant ($X^2 = 3.47$, df = 18, $p<0.01$).

Nuisance Calls and Patient Calls

For the first 21 days of the period covered by this paper, the number of nuisance calls was correlated with the number of patient calls on each day. During this period 657 nuisance calls, 313 calls from new patients, and 221 calls from old patients were received. The correlation between the number of nuisance calls each day and the number of calls from new patients was not significant (Pearson r = -0.22). The correlation between the number of nuisance calls each day and the total number of calls from patients (new patients and old patients) was also not significant (Pearson r = -0.01.).[11,12,13]

The population who make calls classified as nuisance calls differed significantly from the patient population calling the center. The nuisance callers contain significantly more males than the patient population ($X^2=11.09$, df = 1, $p<0.01$). For the nuisance callers 47.5% were males whereas for the new patients 32.4% were males. In addition, the nuisance calls came significantly more often later in the day than patient calls ($X^2=31.82$, df = 3, $p<0.01$).[14]

Are Nuisance Calls Made by Patients Or Pranksters?

It was mentioned in the introduction to this paper that a "nuisance" call is defined as a nuisance by the receiver of the call. A nuisance call may in fact be a call from a potential patient who, for example, may lack the courage to continue the communication once the counselor answers the telephone. Can the calls be categorized as to whether the caller is a potential patient or a prankster? This is almost impossible. There are severely disturbed persons calling the center for help and, no matter how bizarre or flippant the content of the nuisance call, there is always

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[11] Since the counselors were probably much more accurate in recording patient calls than nuisance calls, these correlations are probably only approximations of the true correlations.

[12] Errors in recording nuisance calls have less effect on the contingency tables in the preceding sections since there is no *a priori* reason to suppose that more errors or omissions are made for female callers, as compared to male callers, etc.

[13] Using time periods longer than days, a positive correlation would probably be found.

[14] The proportions of patient calls from males and females and the proportion of patient calls at different times in the day were taken from a representative sample of calls from new patients over a 21 day period.

the possibility that the call comes from a potential patient or indeed from someone who is already a patient.

Hang-ups and calls in which there is only breathing or in which the caller says merely "Wrong number. Sorry" are unclassifiable as to their seriousness or flippancy. On the other hand obscene calls are much more likely to be the result of pranksters. Often the counselor records that the background noise was of a party and this confirms this classification.

"Other" calls can occasionally be judged as pranks by the background noise of laughter or party noises. This however is not a reliable method of classification and certainly may not be valid. In a small sample of nuisance calls classified as suicidal, approximately 45% were judged to be possibly pranks by the author. The others could not be judged with certainty. In a small sample of calls classified as "other," 27% were judged to be possibly by pranksters, 10% were probably by people seeking different persons or organizations, and the remaining 63% were unclassifiable.

Discussion

A suicide prevention center offers an excellent opportunity to study nuisance calls. The Erie County center received a large number of nuisance calls and received them under conditions that facilitated adequate and reliable recording of the content of the call. It might be possible in such a setting to try different techniques to engage the nuisance caller and different techniques to reinforce his behavior. This would be especially useful in the case of the obscene caller.

It can be seen that, using such an organization, relationships have been identified on the nature of "non-patient" calls. "Non-patient" calls occur late in the day and later in the day than calls from patients. Obscene and suicidal calls are made more by males whereas wrong numbers and calls classified as "other" are made more by females. Males tend to call earlier in the day than females.

One question that would be most interesting to investigate is whether and to what extent these calls are made by individuals who have already called the center as a patient or who will subsequently call the center. Many of the calls will come from those who are too timid to make a contact as a patient immediately or who are testing the service (for example, is there somebody there always or is there sometimes a recorded message?). Since a non-patient caller is possibly a future patient caller, the telephone counselor must be patient with these callers and act in a way that will facilitate a subsequent meaningful contact with the center.

References

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SIEGEL, S. 1956 Nonparametric statistics for the behavior al science. New York McGraw-Hill.

A Sample Record

CRANK OR HANG-UP CALLS

It is very important that this form be filled out in the course of the day for purpose of research for Dr. Lester.
For peak periods of crank calls, the form below could just be checked on each line as each call is answered to signify another call received. The general time could be noted afterwards.

DATE: 1/30/69

Time	am	pm	sex	words	Comments
11:50	x		?		
2:20		x	F	heavy breathing	
4:10		x	F	help me, help me	crying
6:30		x	?		hang-up
6:31		x	?		two hang-ups
9:00		x	F	yeah, you can help me	then hung-up
10:20		x	?		hang-up
10:32		x	?		hang-up
11:55		x	?		hang-up
12:05	x		?		hang-up
12:08	x		M	screw the world	then hung-up
12:20	x		F	she had lost her teddy bear	
7:05	x		?		hang-up
7:58	x		?		hang-up
5:55		x	?		hang-up
7:25		x	?		hang-up
8:00		x	?		hang-up

Other Examples

Is this a record? OK. Just checking.
I want to speak to Tony with the curly locks
I'm going to kill myself. Can you help me?
(Then hung-up. Noise in background.)
What day and date is it? The TV guide is wrong.
My wife won't let me take her to bed. (An adolescent.)
I've got the wrong number.
Please help me.
Oh.
No thank you.
Never mind. I changed my mind.

Nuisance Calls: A Point of View

Gene W. Brockopp, Erie County SPCS.

One of the concerns of a crisis center is what to do with the nuisance, prank, fake, or hang-up call.[15] A nuisance call implies being bothered with a trivial or inappropriate situation or condition. It implies that certain calls can, on the basis of their substance or length be defined as non-critical, non-crisis, or non-problem calls, that there is some standard by which we can designate a call as being a nuisance call, whereas other calls of a similar nature will be designated as being real problem calls. It is questionable whether we can define calls into "real" calls and "nuisance" calls. To define a call as a nuisance call is to set up an arbitrary standard as to the type of problem or situation with which we will work. It is to make a judgment and to set up certain criteria that the individual should meet before he makes a call to the center. It forces an individual to make a judgment about the validity or severity of his problem before he attempts to seek help. We feel it is inappropriate to require this and that to do so will eventually be detrimental to the telephone therapy service. Just as a therapist needs some kind of communication before he can work on a problem that his client or patient presents (these communications may come in a variety of ways, many of them non-verbal) the telephone therapist needs calls before he can begin to work on a problem. Any impediment placed in a person's way, which may keep him from making a call, or any movement to force him to predefine the validity of his call before he makes it, would seem to be unnecessary and would place the crisis service in the same category as many other helping agencies, that is, a problem of a client is considered to be a real problem only when the agency defines it as such. For example, some agencies only work with sixteen-year-olds and above, or children, or marriage problems, or psychotics, or individuals with neurotic disorders. The crisis telephone service in contra-distinction to these should be one which is open to all individuals, regardless of their orientation, background or difficulty, to have, through telephone contacts, a potential therapeutic relationship with a helping individual.

Most people who have a problem usually feel uncertain whether or not they should attempt to get help for themselves or whether they should follow the normal or accepted pattern of getting themselves out of the problem without external assistance. Stated another way, people in crisis are often unsure about the validity of their seeking help. The Center should not force these individuals into a situation where they have to decide whether or not their problem is severe enough before they can call. This will mean that the center must be open to all types of

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[15] It is problematical whether a center can effectively reduce nuisance calls. For example, the suicide prevention center of White Plains, New York tried to reduce the number of nuisance calls by placing a news item in the local newspaper: "SNARLING A LIFE LINE The emergency suicide prevention service operated by the Mental Health Association (dial a number for professional counseling) is experiencing a number of crank calls for the first time in its history, a spokesman for the association discloses. In view of the fact that someone really needing help might find that the line is kept busy by some prankster tying up the counseling service's phone, the subject could boil down to technical manslaughter." Although the newspaper ran a subsequent item relating how the volume of nuisance calls had decreased, Elaine Feiden, the coordinator of the Suicide Prevention Service, reports that the article had little impact on the volume of nuisance calls.

calls, many of which will appear on the surface to be of a "nuisance" nature. As a result of this orientation, the Center may receive a number of calls that might best be described as being incomplete, that is, calls which substantial interaction with the helping individual is not allowed to take place because the caller decides to terminate the conversation, or to not allow the conversation to develop. This type of orientation is in agreement with the therapeutic relationship which the Center attempts to set up with each individual, for it lets the caller define his problem as he will, and lets the Center respond to the caller with the assumption of honesty on the part of the caller. In essence, it places all the responsibility on the individual calling, for it does not allow the caller to manipulate the telephone therapist through having him make a decision whether or not the call is real. We have found in our Center that even the most obvious type of "nuisance" call, that of a call from teenagers at a party, often can begin to focus on a problem if handled correctly. What we are implying by this, is that the individual who makes a "nuisance" or incomplete call to a suicide prevention center may not be completely aware of why he is doing this and may give the impression of being a non-serious caller, but in reality may be setting up a situation for the Center in which their response to him as a nuisance caller may be unconsciously predetermined by him as a way in which he sets himself up to be rejected by them as he has been by other agencies and organizations. Therefore, it seems to be imperative for the Center to allow itself to be manipulated to the possibility of an incompleted call, and to accept this as a part of the price it has to pay to be available to all individuals.

Another point seems to be important here also. Any person, who makes a call classified as either a "nuisance" call or as an incomplete call, should be considered to have a problem, even though he may not recognize it at the time. To cut off the person by making a statement such as "one should only call when one has a problem to talk about," would seem to reinforce his not calling because of the possibility of rejection. Conversely, accepting any call as a call from an individual with a problem, regardless of what takes place, or how short the call is, should reinforce the individual that a call to the Center will be handled in a direct way with full acceptance of the individual and his problem. Stated another way, the person may not be consciously aware that he has a problem at the time he is making the "nuisance" call but he will be left with the attitude that the Center does not play games with him, and that it will respond to any call in a direct and facilitative way. When the problem he has comes into his conscious awareness, the possibility of his making a call to the Center is greatly enhanced.

Based on the foregoing considerations, I would like to make the following suggestions:

1. There is no such thing as a nuisance call at a 24-hour telephone emergency service and no call being taken at the center should be designated as such, since by designating a call in this way is to prejudice one against the caller and to preclude, if not eliminate, the possibility of assistance being given to the caller for it gives the telephone therapist a feeling that she can handle the call in a less serious, less considerate, less concerned manner.

2. Calls coming in to the Center should be designated as "complete" or "incomplete" calls. Complete calls are those in which the termination of the call is made through the mutual assent

of both parties. Incomplete calls are those in which the termination of the call is determined by one of the parties without consideration for the other individual.

3. The point of view of the telephone therapist should be that there is no such thing as a wrong number or a mistake in dialing a number. Every effort should be made to engage the person who places this type of a call in a conversation by being helpful and concerned about giving assistance to the individual. Persons who make these the calls are often giving the telephone therapist a test to determine whether or not they will be accepted before they reveal that they have actually placed the call to the Suicide and Crisis Service.

4. The telephone service must allow itself to be used or manipulated (if necessary) but must answer the calls in a straightforward, direct and honest way. After a period of time, it is possible for a telephone therapist to begin to hear the "ring" of an "honest" call, or of a "dishonest manipulative" call. But to make this type of judgment can have negative consequences for the care or treatment of the individual, and may result in the telephone therapist making a serious error. We have found that when we play a call out, even though we may suspect it may be a "crank" or a manipulative "fake" call, the individual will sometimes call back after he hangs up the phone, and tells us that he is not in danger, and that he is sorry he has placed the call.

5. Each time a person calls the Center and gets a response which is positive and facilitative, regardless of whether the person calling is calling with an overt problem, the Center is developing the concept in the community that individuals at the Center will not "play games" with people on the telephone, but that they will listen to them honestly and directly and respond to them in this manner. Rather than being detrimental, the number of incomplete calls the Center receives can be looked on as being a positive measure of interest that a community has in the Center, and as a measure of the increased number of individuals in the community who know about the Center and are calling it to see if it is really there.

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